CHA Special REPORT

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Financial Pressures Continue for California Hospitals

National/State Economic Developments

By fall 2001, California was showing signs of an economic slowdown brought about by a number of factors. The international economic climate slowed, depressing sales of California exports, and the terrorist attacks in September dealt a severe blow to California industries dependent on tourism. The extraordinary rise and fall of the stock market, and the volatility of income tax revenues from capital gains and stock options, magnified this slowdown. These factors coincided to produce the most precipitous decline in state revenues since World War II. California now faces a $14 billion budget shortfall causing grave concern to California residents and providers.

Overall Financial Health

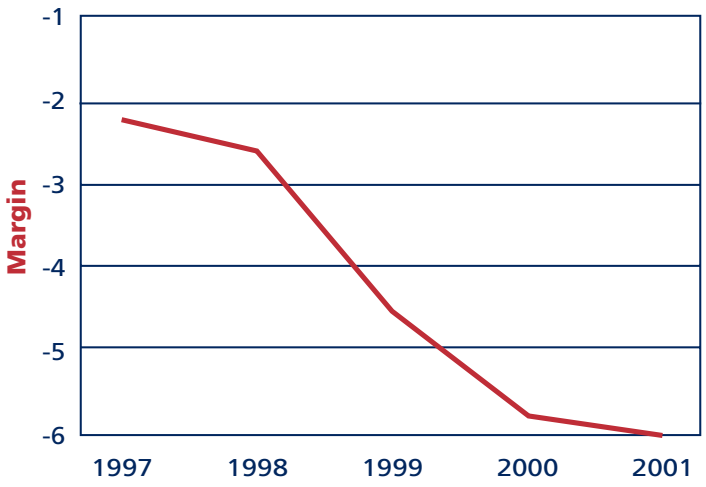
California's health care system is a unique, heavily managed care marketplace that has resulted in a delivery system with relatively low cost and low utilization. Payments from payers for hospital services are below the national average. However, these characteristics, which have contributed to California's health care efficiencies, also have helped create a serious and growing financial vulnerability among the state's hospitals.

Most health care services are provided prior to obtaining, or seeking, payment. The public views hospital services as a right, and physicians — not hospitals — determine the course of treatment and, hence, the cost of treatment. Even the payment for treatment is determined by a third party, government or insurance company. Hospitals are typically a purchaser of services, but often not the end user. Despite the unique business environment in which hospitals operate, the measure of viability is not. Revenues must offset expenditures for hospitals to remain solvent. Operations must support continued investment (this will not be the case with expenditures outlined in the next two sections). Hospitals cannot survive on operations with perpetual under-funding from government and commercial payers. Providing uncompensated care to more than 7 million uninsured Californians only adds to the relentless and increasing financial pressures on hospitals.

In addition to the severe financial pressures brought about by inadequate payment systems, hospitals are forced to comply with numerous unfunded government mandates, and face burdens of workforce shortages, new technology and rising operational costs.

California Office of Statewide Health Planning and Development (OSHPD) data indicate that more than 66 percent of California hospitals have negative patient-care margins. Patient revenues to hospitals for services rendered have been ratcheted down for two decades. Beginning in the early 1990s, patient-care revenue no longer covered the cost of providing care. The actual patient-care margin (net patient revenue less expenses) in 2001 was a negative 6 percent, according to OSHPD data. *(See Figure 1.)*

Figure 1 — **Trends in Hospital Patient Care Margins**



Source: Office of Statewide Health Planning and Development

This means that hospitals must rely on investment income and other revenue sources to offset the losses incurred through reimbursement for patient care. The recent decline in investment income will further undercut this fine balance. According to OSHPD, total California hospital margins (including non-operating revenue) are only 3.2 percent, less than half of what they were just three years ago.

In 1999, Standard and Poor's downgraded eight California hospitals and health systems, while issuing no upgrades. In

2000, the trend continued in California, with 10 downgrades and no upgrades. Although there is some indication that there may be stabilization in the medium term, due in part to successful negotiation of rate increases for managed care contracts and a slight softening of reimbursement pressures, California's hospital and health system ratings are currently somewhat more volatile than the sector as a whole, indicating that deterioration may continue in the near term.

Patients Have Greater Needs

Patients are older and sicker, requiring more intensive services and support care. People 65 years of age and older are the fastest growing segment of the population. Medicare payments will become even more important as the population ages. According to the National Economic Council, the number of elderly in California will almost double in the next 25 years.

According to Halsted Holman, M.D., professor of medicine at Stanford University and an expert in the treatment of chronic diseases, the average person over age 65 has two identifiable chronic diseases. Today, 70 percent of all medical dollars go to the treatment of such diseases. In 2020, with so many more people over the age of 65, the health care delivery industry may not be able to handle the volume, warns Holman.

Medicare Cutbacks

In 1997, the federal Balanced Budget Act (BBA) imposed on hospitals more than $60 billion in Medicare payment cuts for 1998 through 2002. This translated into direct Medicare reductions of more than $6 billion to California hospitals. The Balanced Budget Refinement Act (BBRA) of 1999 represented approximately 7 percent in BBA relief. Medicare, Medicaid and State Child Health Insurance Plan Benefits Improvement and Protection Act (BIPA) of 2000, represented an additional 11 percent in BBA relief for a total BBA relief nationwide of approximately 18 percent. Despite this BBA relief, hospitals are still reeling from the nearly $5 billion in cuts from Medicare.

Almost 40 percent of California's 4 million Medicare beneficiaries are enrolled in capitated health plans (compared to 15 percent nationwide). Medicare health plans generally pay hospitals less than they would receive if the services were paid for on a fee-for-service basis.

Medi-Cal Payments

Since 1982, California's Medi-Cal payments have dropped in comparison to Medicaid programs in other states. According to the governor's January proposed budget for 2002-03 *(see Figure 2)*, by percentage of state population, California served about 18.9 percent of state residents, exceeded only by New York. California provides more optional benefits than any of the other 10 large states and at one of the lowest average cost-per-recipient rates in the nation — $2,693 per beneficiary versus a national average of $3,895 per beneficiary and the New York average of $6,759 in federal fiscal year (FY) 1998.

Figure 2 —

Federal Medicaid Program – Interstate Comparisons
10 Most Populous States – Federal Fiscal Year 1998

	Annual Eligibles as a Percentage of Total Population	Expenditures, Total Funds (Dollars in Millions)	Expenditures Per Eligible
All States	15.3	$161,097	$3,895
New York	19.3	23,659	6,759
New Jersey	10.6	5,562	6,483
Pennsylvania	14.3	8,995	5,230
Ohio	12.5	7,201	5,135
Michigan	13.8	5,884	4,343
Texas	13.6	10,383	3,873
Illinois	14.8	6,800	3,811
Florida	13.7	6,560	3,215
Georgia	16.0	3,736	3,054
California	18.9	16,671	2,693

Sources: National Association of State Budget Officers, the US Census Bureau, and the federal Department of Health and Human Services, Centers for Medicare & Medicaid Services.

California hospitals recently reached a settlement agreement in the three lawsuits that have been ongoing since 1990, challenging the adequacy of fee-for-service rates paid to hospitals for Medi-Cal outpatient services. The settlement agreement includes a 30 percent rate increase for these services. After this rate increase takes effect, hospitals will be reimbursed for approximately 45 percent of costs. Clearly, a significant gap still remains.

As in Medicare, California has the highest percentage and number of Medicaid beneficiaries enrolled in capitated plans. Also similar to Medicare, Medi-Cal health plans generally pay hospitals less than Medi-Cal pays for fee-for-service inpatient care.

Several other Medi-Cal components that factor into hospitals' worsening financial condition are discussed below.

Medicaid Upper Payment Limit

The Centers for Medicare & Medicaid Services (CMS) issued a final rule in January 2002 to reduce the Medicaid Upper Payment Limit (UPL) for public hospitals from 150 percent to 100 percent. This change will significantly cut funding for health care services to low-income populations and destabilize California's entire health care industry. California will lose at least $1 billion in federal Medicaid payments to safety-net hospitals over the course of the transition outlined in the rule. Once the rule is fully implemented, the loss to California will be at least $300 million per year, jeopardizing access to vital health care services for communities throughout the state.

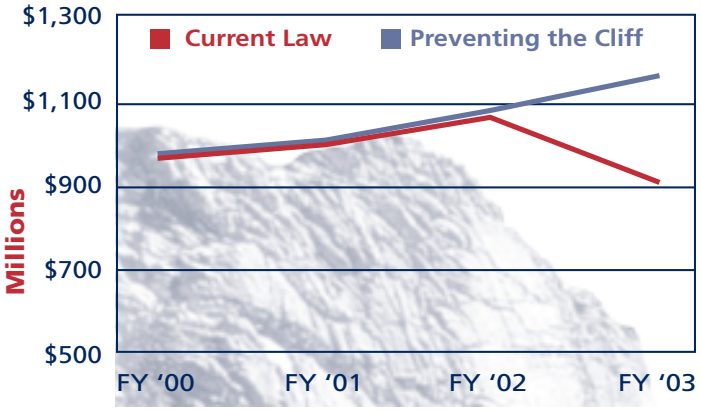
Although the higher payment limit applies only to public hospitals, the structure of California's Medi-Cal program intrinsically links public- and private-sector hospitals. Private safety-net hospitals, children's hospitals and teaching hospitals — as well as public hospitals — all receive supplemental Medi-Cal payments and all will be seriously harmed by the implementation of the final rule.

DSH 'Cliff'

The Medicaid disproportionate-share hospital (DSH) program was designed to help providers that care for a large portion of the poor and uninsured. Because California has the highest standard for qualifying for the DSH program, Medi-Cal DSH funds are specifically targeted to the safety-net providers. Currently, approximately one-fourth of California hospitals qualify for Medi-Cal DSH funds.

BBA included a 20 percent reduction in Medicaid DSH funding to states. In subsequent years, Congress took action to help stabilize funding to some health care providers; however, these measures did not focus significantly on the Medicaid program, which services low-income patients. As a result, federal Medicaid DSH funds to California have already been cut more than $264 million over recent years. Although BIPA postponed until 2003 further severe reductions in Medicaid DSH funding, the legislation provided only a stopgap to a looming fiscal crisis. Under current law, deep reductions in the Medicaid DSH program (the DSH "cliff") will take place in federal FY 2003 and beyond *(see Figure 3)*. Without further congressional action, federal Medicaid DSH payments to California will be cut an estimated $184 million next FY (17 percent of the total program). The Medicaid DSH program is critical to maintaining the fiscal viability of public and private safety-net providers and allows them to deliver needed health services to low-income and uninsured Californians.

Figure 3 — **Federal Medicaid DSH Allotments to California**



Source: Federal Benefits Improvement and Protection Act of 2000

Federal Medical Assistance Percentage

The Federal Medical Assistance Percentage (FMAP) is the percentage of Medi-Cal costs reimbursed by the federal government and is based on U.S. Bureau of Census estimates of state population. The current FMAP is 51.4 percent. However, in 2002-03, it is expected to decrease to 50 percent. To absorb the loss in federal funds the state General Fund would need to be increased by $193.8 million. In the challenging economic environment in California, this potential additional cost to the state is a cause for concern among health care providers.

Disaster Readiness

Given the events of Sept. 11, a heightened awareness now exists regarding the possibility of terrorist and bioterrorist incidents. Many experts agree that it is a matter of "when" and not "if" a future mass casualty attack will occur. The stakes have clearly been raised since Sept. 11. In a nuclear, biological or chemical (NBC) attack, hospitals would be severely challenged without access to additional resources. Field hospitals and other first-response capabilities must be developed to help NBC victims.

The American Hospital Association (AHA) recently identified the resources necessary for California hospitals to increase their ability to respond to an NBC attack in the areas of communication and notification; disease surveillance, disease reporting and laboratory identification; personal protective equipment; facilities; dedicated decontamination facilities; medical/surgical and pharmaceutical supplies; training and drills; and mental health resources. Conservative estimates indicate California hospitals need to initially invest $50 million for disaster preparedness with additional annual expenditures exceeding $5 million.

Health Care Workforce Shortage

California and the nation face a serious shortage of qualified personnel, especially nurses and pharmacists. Hospitals cannot fill many of their vacancies. Unlike past nurse shortages, which tended to be cyclical in nature, the current situation is not expected to ease in the foreseeable future.

According to a report by the California Strategic Planning Committee on Nursing, conservative estimates indicate that California will have a shortfall of approximately 25,000 nurses by 2006. Projections for the shortage are based on a ratio of 566 registered nurses (RNs) per 100,000 patients and an increase in population of 17.7 million. Although the ratio of RNs per 100,000 patients increased to 585 by 1999, it was the lowest RN-to-patient ratio in the nation.

The nurse shortage is further eroding California hospitals' financial position. According to a recent CHA survey, hospitals are paying registry and traveling nurses twice as much as staff nurses (approximately $25 to $35 per hour for staff

nurses; $60 to $75 per hour for registry/traveling nurses). The same survey indicates an average urban California hospital is spending approximately $1 million to $1.5 million annually for registry/traveling nurses above the costs that would be incurred if the nurses were employed by the hospital.

The workforce shortage is further exacerbated by the mandated nurse-to-patient ratios discussed below.

The Uninsured

California has more than 7 million residents without health insurance and another 4 million who are inadequately insured, which limits their access to health care services and, thus, optimum health. Even with the introduction of new and enhanced public and private programs targeting the needs of uninsured families, the number of uninsured Californians is projected to increase throughout this decade due in part to the economic slowdown. Numerous research studies have examined the reasons why so many Californians are uninsured and often cite economic, informational and motivational factors.

Emergency Services

According to the Legislative Analyst's Office (LAO), emergency departments (ED) and trauma centers face growing financial losses. Under state and federal law, any person seeking care at an ED must be provided with that care regardless of ability to pay. According to OSHPD, in 1999, 14 percent of ED patients were uninsured and 7 percent were paid for by county indigent programs, resulting in little or no compensation to the hospital for these patients. The problem is aggravated by the use of EDs and trauma centers as a point of access for nonemergency services. The California Medical Association estimates that more than 80 percent of all Medi-Cal and uninsured patient visits to EDs were for conditions that could have been treated in a nonemergency setting.

Energy

As the public and policy-makers in California continue to grapple with the aftereffects of the state's 2001 energy crisis, California residents and businesses, including hospitals, continue to absorb significant increases in costs. The majority of hospitals' energy costs increased an average of 75 percent in 2001.

Technology

Health care costs in the U.S. and California are increasing faster than the rate of inflation, wages and economic growth. There are many new medical discoveries, such as CT scans, MRIs, sophisticated tests, prescription drugs and surgical procedures. New medical treatments are available to make pregnancy safer, cure childhood diseases and rehabilitate people with disabilities. These improvements help people live longer, but often cost more than previous medical technology. All of these advances in medical knowledge increase the demand for services but also drive up costs. California hospitals believe the cost of new and improved health care technology is a fair trade toward the vision of "an optimally healthy society." However, hospitals and other providers are put in financial jeopardy if they are expected to fund the costs of these new technologies.

Unfunded Mandates

Following are examples of unfunded mandates imposed upon hospitals. The most expensive of these mandates is related to earthquakes.

Seismic Safety

SB 1953 (Chapter 740, Statutes of 1994) was enacted following the structural and nonstructural (mechanical, electrical and plumbing) damage hospitals experienced as a result of the January 1994 Northridge earthquake. The law requires hospitals to comply with bracing and anchorage of essential nonstructural systems by 2002; certain life/safety structural and additional nonstructural requirements by 2008; and structural and nonstructural requirements that bring hospitals into substantial compliance with the 1973 Hospital Facilities Seismic Safety Act by 2030.

Original cost estimates for SB 1953 were at least $14 billion. SB 1953 costs are now estimated to be at least $24 billion because the vast majority of hospital buildings cannot incrementally be brought into substantial compliance with the mandate. In reality, they need to be rebuilt. Retrofitting to meet 2008 requirements is less costly in the short run but can be much more costly in the long run because most 2008-retrofitted hospital buildings will have to be replaced to meet 2030 requirements. The estimated SB 1953 costs are in 1999 dollars and do not include costs for inflation, financing, land, parking requirements, and the increased demand for limited hospital designers and contractors. The $24 billion cost of SB 1953 exceeds the total undepreciated assets of all California hospitals.

SB 1953 will force the closure of some hospitals prior to an earthquake unless there is access to capital or the SB 1953 implementation schedule is amended to make it more financially feasible to implement. The closure of hospitals due to SB 1953 will create access-to-care and other problems. The unanticipated costs may damage the state's health care safety net; exacerbate personnel shortages due to the elimination of training programs; and result in job losses and increased insurance premiums.

Nurse-to-Patient Ratios

In January 2002, Gov. Davis released a set of proposed nurse-to-patient staffing ratios, as required by state law (AB 394, 1999). The proposed ratios are the first-ever attempt by any state in the nation to establish a predetermined ratio of nurses to patients for all hospital units. The proposed ratios will be subject to the normal regulatory process — and likely will go into effect in spring 2003.

Because California faces the most serious nurse shortage in the nation, some hospitals may have to shut down some services or significantly reduce the capacity of their services in order to comply with the law. Statewide, California hospitals currently operate with a more than 15 percent RN vacancy rate — meaning that more than one out of every six nursing positions in hospitals is not filled with regular hospital employees. Registry and traveling nurses are used to fill the gap. Once the proposed staffing ratios are in effect, the nurse shortage may become even more acute and access to patient-care services may be jeopardized. For example, if a hospital has 10 treatment bays in its ED but only has enough nurses to staff five of those beds and be in compliance with the law, half of the hospital's ED capacity may have to be taken out of service. The net result would be reduced access to emergency-care services in a local community. Patients' conditions often change by the hour, and hospitals face a continual turnover of patients with diverse medical needs, all of which impact staffing requirements. It is highly unlikely that hospitals will be able to meet the prescribed ratios at all times.

HIPAA

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which contains requirements that ensure individuals with health insurance are treated fairly, and establishes significant privacy, confidentiality, reporting and compliance requirements.

Hospitals and health systems will have to allocate substantial resources to comply with HIPAA's complex privacy regulation. AHA estimates it will cost California hospitals at least $400 million to comply with just three of the provisions in HIPAA's privacy regulation, and perhaps up to $2.2 billion if major information systems reconfiguration or replacement must be undertaken to comply. The Department of Health and Human Services' (DHHS) initial estimate of $320 million over five years did not even include these three provisions. Industry experts and consultants may not agree on an estimated cost of HIPAA, but all agree that DHHS' estimates of HIPAA compliance are too low.

Despite the prohibitive costs of implementing HIPAA, there is no adjustment in Medicare payments or in any other program to cover these dramatic new expenses. While hospitals strongly support the uniformity that HIPAA affords, this is yet another example of an unfunded mandate on hospitals.

Bottom Line

The high-quality health care system Californians rely on is not sustainable with perpetual under-funding from government and private payers. To maintain the health care delivery system all Californians deserve, California hospitals need fair and adequate payments from Medicare, Medi-Cal and all other payers; the ability to hire the appropriate workforce; resources to cover expenses such as energy; and the financial support to comply with the costs of meeting local, state and federal regulations.

To reach CHA's goal that every Californian has equitable access to affordable, high-quality, medically necessary health care, the following must be achieved:

- State Medi-Cal, federal Medicare and commercial health plan payments must be adequate and timely.
- Funds and financial assistance must be provided for projects required by state seismic-safety laws.
- Laws must be enforced to ensure private third-party payers adequately reimburse hospitals and physicians for all covered services, including emergency care, in a timely manner.
- Support for safety-net providers that serve poor and uninsured patients must be increased and stabilized.
- Incentives among providers and between providers and payers must be aligned.
- Hospitals cannot be expected to absorb unfunded mandates.

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